



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

AMARBIR MATTEWAL MD
218 A W MAIN STE D
BELLEVILLE IL 62220

Respondent Name

TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box

Box Number 54

MFDR Tracking Number

M4-13-2485-01

MFDR Date Received

MAY 28, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please review the denial for the claim on invoice #000010502806. This was a correction to the original claim for DOS 7/10/12 billed on invoice #000010314136. An initial consultation (99254) was originally billed and denied on the first invoice (000010314136); the correction as an initial inpatient visit was done on invoice #000010502806."

Amount in Dispute: \$325.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor provided inpatient E/M services to the claimant on the date above then billed Texas Mutual code 99254. Texas Mutual reviewed the bill and attached documentation, noted that code 99254 had been discontinued by Medicare, and declined to issue payment. The requestor submitted a new bill for date 7/10/12 with code 99222. Texas Mutual received this bill 10/22/2012, well past the 95 day time line of Rule 133.20, and declined to issue payment."

Response Submitted by: Texas Mutual Insurance Co., 6210 E. Hwy 290, Austin, TX 78723

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
JULY 10, 2012	CPT Code 99222	\$325.00	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.

3. 28 Texas Administrative Code §102.4 sets out the rules for non-Commission communications.
4. Texas Labor Code §408.027 sets out the rules for timely submission of a claim by a health care provider.
5. Texas Labor Code §408.0272 sets out the rules for certain exceptions for untimely submission of a claim by a health care provider.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 29 – The time limit for filing has expired.
 - 731 – Per 133.20 provider shall not submit a medical bill later than the 95th day after the date the service, for services on or after 9/1/05.

Issues

1. Was the request for medical fee dispute resolution timely submitted to the Division?
2. Did the requestor forfeit the right to reimbursement for the services in dispute?

Findings

1. Review of the documentation submitted by the requestor finds that the requestor initially billed CPT Code 99254 in a timely manner and was denied reimbursement by the respondent using denial code “714 – Accurate coding is essential for reimbursement. CPT/HCPCS billed incorrectly. Services are not reimbursable.” as this code is not payable by Medicare. The requestor then submitted a new bill on October 18, 2012 billing CPT Code 99222. In accordance with 28 Texas Administrative Code §133.20(g), “Health care providers may correct and resubmit as a new bill an incomplete bill that has been returned by the insurance carrier.” The requestor in this dispute was required to submit the corrected medical bill not later than 95 days after the date the disputed services were provided.
2. Texas Labor Code §408.027(a) states, in pertinent part, that “Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment.” 28 Texas Administrative Code §102.4(h) states that “Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on: (1) the date received, if sent by fax, personal delivery, or electronic transmission or, (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday.” Review of the submitted information finds no documentation to support that the corrected medical bill was submitted within 95 days from the date the services were provided. Therefore, pursuant to Texas Labor Code §408.027(a), the requestor in this medical fee dispute has forfeited the right to reimbursement due to untimely submission of the medical bill for the services in dispute.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

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Signature	Medical Fee Dispute Resolution Officer	Date

September 25, 2013

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.